FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034157

Facility Name: WOODBRIDGE NURSING PAVILION

Address: 2242 N. KEDZIE AVE. (Number) CHICAGO (City) 60647 (Zip Code)

County: COOK

Telephone Number: (773) 486-7700 **Fax #** (773) 486-7937

IDPA ID Number: 363585796001

Date of Initial License for Current Owners: 08/01/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) _____
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	222	Skilled (SNF)	222	81,030	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	222	TOTALS	222	81,030	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,011	850	3,452	14,313	8
9	SNF/PED					9
10	ICF	54,566	3,604	214	58,384	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,577	4,454	3,666	72,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.72%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/1/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 3,449

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	239,306	29,449	7,200	275,955		275,955		275,955			1
2	Food Purchase		279,899		279,899	(57,707)	222,193	(764)	221,429			2
3	Housekeeping	200,259	47,188		247,447		247,447		247,447			3
4	Laundry	102,164	25,056		127,220		127,220		127,220			4
5	Heat and Other Utilities			151,516	151,516		151,516	1,591	153,107			5
6	Maintenance	75,349	32,003	58,512	165,864		165,864	6,866	172,730			6
7	Other (specify):*							1,058	1,058			7
8	**TOTAL General Services**	617,078	413,595	217,228	1,247,901	(57,707)	1,190,195	8,751	1,198,946			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,260,812	126,785	116,729	2,504,326		2,504,326	(6,429)	2,497,897			10
10a	Therapy		1,547	15,017	16,564		16,564	(169)	16,395			10a
11	Activities	119,157	4,881	4,290	128,328		128,328		128,328			11
12	Social Services	46,030		3,482	49,512		49,512		49,512			12
13	Nurse Aide Training											13
14	Program Transportation			2,818	2,818		2,818		2,818			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,425,999	133,213	145,936	2,705,148		2,705,148	(6,598)	2,698,550			16
	C. General Administration											
17	Administrative	111,640		153,103	264,743		264,743	194,211	458,954			17
18	Directors Fees											18
19	Professional Services			409,109	409,109	(233)	408,876	(357,085)	51,792			19
20	Dues, Fees, Subscriptions & Promotions			76,404	76,404		76,404	(54,857)	21,547			20
21	Clerical & General Office Expenses	109,942	1,978	56,502	168,422		168,422	59,126	227,548			21
22	Employee Benefits & Payroll Taxes			631,925	631,925	57,707	689,632	(18)	689,614			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,250	1,250		1,250	424	1,674			24
25	Other Admin. Staff Transportation			1,189	1,189		1,189		1,189			25
26	Insurance-Prop.Liab.Malpractice			239,292	239,292		239,292	1,433	240,725			26
27	Other (specify):*							53,064	53,064			27
28	**TOTAL General Administration**	221,582	1,978	1,568,774	1,792,334	57,474	1,849,808	(103,702)	1,746,106			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,264,659	548,786	1,931,938	5,745,383	(233)	5,745,150	(101,548)	5,643,602			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION #0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			77,508	77,508		77,508	(9,304)	68,204			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			56,787	56,787		56,787	(49,983)	6,804			32
33	Real Estate Taxes			248,302	248,302	233	248,535	4,627	253,162			33
34	Rent-Facility & Grounds			1,092,980	1,092,980		1,092,980	(50)	1,092,930			34
35	Rent-Equipment & Vehicles			11,884	11,884		11,884	13,366	25,250			35
36	Other (specify):*											36
37	TOTAL Ownership			1,487,461	1,487,461	233	1,487,694	(41,344)	1,446,350			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		148,792	239,229	388,021		388,021	(16,555)	371,466			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,545	121,545		121,545		121,545			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		148,792	360,774	509,566		509,566	(16,555)	493,011			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,264,659	697,578	3,780,173	7,742,410		7,742,410	(159,448)	7,582,962			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,483)	30		9
10	Interest and Other Investment Income	(56,283)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(171)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(50)	21		18
19	Entertainment				19
20	Contributions	(8,260)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,536)	21		24
25	Fund Raising, Advertising and Promotional	(29,955)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,414)	20		28
29	Other-Attach Schedule	(49,773)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (169,925)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	10,477		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 10,477		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (159,448)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
WOODBRIDGE NURSING PAVILION
ID# 0034157
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BUILDING COMPANY FRANCHISE TAX	$ (50)	21	1
2	COLLECTION FEE	(959)	21	2
3	BANK CHARGES	(68)	21	3
4	DISCOUNTS EARNED	(593)	02	4
5	PPA-NURSING SUPPLIES	(1,751)	10	5
6	PPA-CONTRACT NURSING	(1,018)	10	6
7	PPA-DUES FEES	(11,723)	20	7
8	PPA-OFFICE	(6,525)	21	8
9	PPA-EMPLOYEE BENEFITS	(18)	22	9
10	PPA-INSURANCE	(3,805)	26	10
11	PPA-REPAIRS AND MAINTENANCE	(2,685)	06	11
12	PPA-INTEREST	(15)	32	12
13	PPA-EQUIPMENT RENTAL	(170)	35	13
14	PPA-BED RENTAL	(1,654)	39	14
15	PPA-MEDICAL SUPPLIES	(8,374)	39	15
16	ICLTC COPE DUES	(3,585)	20	16
17	CAPITALIZED R&M	(6,262)	6	17
18	NON-ALLOWABLE LEGAL	(518)	19	18
19				19
20				20
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99				99
100				100
101	Total	(49,773)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(764)											(764)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,591									1,591	5
6	Maintenance	(8,947)		4,877	10,936								6,866	6
7	Other (specify):*			128		930							1,058	7
8	**TOTAL General Services**	(9,711)		6,596	10,936	930							8,751	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,769)						(3,660)					(6,429)	10
10a	Therapy						(169)						(169)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,769)					(169)	(3,660)					(6,598)	16
	C. General Administration													
17	Administrative			(153,103)	347,314								194,211	17
18	Directors Fees													18
19	Professional Services	(518)		(356,567)									(357,085)	19
20	Fees, Subscriptions & Promotions	(55,937)		1,080									(54,857)	20
21	Clerical & General Office Expenses	(14,188)	50	63,421	9,843								59,126	21
22	Employee Benefits & Payroll Taxes	(18)											(18)	22
23	Inservice Training & Education													23
24	Travel and Seminar			424									424	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(3,805)		5,238									1,433	26
27	Other (specify):*			10,901		42,163							53,064	27
28	**TOTAL General Administration**	(74,466)	50	(428,606)	357,157	42,163							(103,702)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(86,945)	50	(422,010)	368,093	43,093	(169)	(3,660)					(101,548)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(16,483)		7,179									(9,304)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(56,298)		6,315									(49,983)	32
33	Real Estate Taxes			4,627									4,627	33
34	Rent-Facility & Grounds		(50)										(50)	34
35	Rent-Equipment & Vehicles	(170)		13,536									13,366	35
36	Other (specify):*													36
37	TOTAL Ownership	(72,951)	(50)	31,657									(41,344)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(10,028)					(4,026)	(2,501)					(16,555)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(10,028)					(4,026)	(2,501)					(16,555)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(169,925)		(390,353)	368,093	43,093	(4,195)	(6,161)					(159,448)	45

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 1,092,980	WOODBRIDGE BUILDING, LLC		$	$ (1,092,980)	1
2	V	34	RENTAL EXPENSE		WOODBRIDGE BUILDING, LLC		1,092,930	1,092,930	2
3	V	21	FRANCHISE TAX		WOODBRIDGE BUILDING, LLC		50	50	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,092,980			$ 1,092,980	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 1,591	$ 1,591	15
16	V	6	REPAIRS & MAINT.				4,877	4,877	16
17	V	7	EMP.BEN. - GEN. SERVICES				128	128	17
18	V	19	PROFESSIONAL FEES				3,233	3,233	18
19	V	20	DUES AND SUBSCRIPTIONS				1,080	1,080	19
20	V	21	CLERICAL & GENERAL				63,421	63,421	20
21	V	24	SEMINARS AND TRAVEL				424	424	21
22	V	26	INSURANCE				5,238	5,238	22
23	V	27	EMP.BEN. - GEN. ADMIN.				10,901	10,901	23
24	V	30	DEPRECIATION				7,179	7,179	24
25	V	32	INTEREST				6,315	6,315	25
26	V	33	REAL ESTATE TAXES				4,627	4,627	26
27	V	35	EQUIPMENT RENTAL				13,536	13,536	27
28	V	17	MANAGEMENT FEES	153,103				(153,103)	28
29	V	19	BOOKKEEPING FEES	359,800				(359,800)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 512,903			$ 122,550	$ * (390,353)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 10,936	$ 10,936	15
16	V	10	NURSING CMP - SUE G.						16
17	V	17	ADMIN. CMP. - M. MAUER				61,092	61,092	17
18	V	17	ADMIN. CMP. - M. AARON				90,400	90,400	18
19	V	17	ADMIN. CMP. - F. AARON						19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN				125,588	125,588	20
21	V	17	ADMIN. CMP. - S. KOPLIN				17,370	17,370	21
22	V	17	ADMIN. CMP. - D. MAGAFAS						22
23	V	17	ADMIN. CMP. - E. CASSON						23
24	V	17	ADMIN. CMP. - S. BOGEN						24
25	V	17	ADMIN. CMP. - S. LEVY				23,669	23,669	25
26	V	17	ADMIN. CMP. - HOWARD ALTER						26
27	V	17	ADMIN. CMP. - NON-OWNER				29,195	29,195	27
28	V	21	CLERICAL CMP. - S. AARON				9,843	9,843	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 368,093	$ * 368,093	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 930	$ 930	15
16	V	15	EMP. BEN.- SUE G.						16
17	V	27	EMP. BEN.- M. MAUER				2,655	2,655	17
18	V	27	EMP. BEN.- M. AARON				3,388	3,388	18
19	V	27	EMP. BEN.- F. AARON						19
20	V	27	EMP. BEN.- S. GOLDSTEIN				21,005	21,005	20
21	V	27	EMP. BEN.- S. KOPLIN				5,498	5,498	21
22	V	27	EMP. BEN.- D. MAGAFAS						22
23	V	27	EMP. BEN.- E. CASSON						23
24	V	27	EMP. BEN.- S. BOGEN						24
25	V	27	EMP. BEN.- S. LEVY				3,416	3,416	25
26	V	27	EMP. BEN.- HOWARD ALTER						26
27	V	27	EMP. BEN.- NON-OWNER				4,353	4,353	27
28	V	27	EMP. BEN. - S. AARON				1,848	1,848	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 43,093	$ * 43,093	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 9,419	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 9,250	$ (169)	15
16	V	19	PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	224,169	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	220,143	(4,026)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 233,588			$ 229,393	$ * (4,195)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	25,389	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	21,729	$ (3,660)	15
16	V	39	ANCILLARY EXPENSE	17,347	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	14,846	(2,501)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 42,736			$ 36,575	$ * (6,161)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURY AARON	OWNER	ADMIN	24.86%	SEE ATTACHED	7.41	18.53%	Dynamic Sal	$ 90,400	17-7	1
2	MARSHALL MAUER	OWNER	ADMIN	6.75%	SEE ATTACHED	6.73	16.83%	Dynamic Sal	61,092	17-7	2
3	SHARON AARON	RELATIVE	ADMIN	0.00%	SEE ATTACHED	6.73	16.83%	Dynamic Sal	9,843	17-7	3
4	DENNIS NEHMER	OWNER	MAINTENANCE	0.59%	SEE ATTACHED	7.41	18.53%	Dynamic Sal	10,936	6-7	4
5	SUE KOPLIN	OWNER	ADMIN	0.59%	SEE ATTACHED	9.71	24.30%	Dynamic Sal	17,370	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 189,641		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	441,841	13	$ 9,671	$	72,697	$ 1,591	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	441,841	13	29,639	3,380	72,697	4,877	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	441,841	13	778		72,697	128	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	441,841	13	19,651		72,697	3,233	4
5	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	441,841	13	6,566		72,697	1,080	5
6	21	CLERICAL & GENERAL	PATIENT DAYS	441,841	13	385,463	300,175	72,697	63,421	6
7	24	SEMINARS AND TRAVEL	PATIENT DAYS	441,841	13	2,576		72,697	424	7
8	26	INSURANCE	PATIENT DAYS	441,841	13	31,835		72,697	5,238	8
9	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	441,841	13	66,254		72,697	10,901	9
10	30	DEPRECIATION	PATIENT DAYS	441,841	13	43,634		72,697	7,179	10
11	32	INTEREST	PATIENT DAYS	441,841	13	38,384		72,697	6,315	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	441,841	13	28,121		72,697	4,627	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	441,841	13	82,269		72,697	13,536	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 744,841	$ 303,555		$ 122,550	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	10	59,032	59,032	7	10,936	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,744	32,744			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	12	363,103	363,103	7	61,092	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	10	487,988	487,988	7	90,400	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	193,312	193,312			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	153,497	153,497	30	125,588	6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	8	71,542	71,542	10	17,370	7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	87,437	87,437			8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	31,246	31,246			9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	2	54,060	54,060			10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	12	140,632	140,632	8	23,669	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	12	157,563	157,563	8	29,195	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	12	58,502	58,502	7	9,843	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,902,658	$ 1,902,658		$ 368,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	10	5,020		7	930	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40	1	3,128				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	12	15,782		7	2,655	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	10	18,288		7	3,388	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	6	28,556				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	37	2	25,672		30	21,005	6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	8	22,644		10	5,498	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	12,125				8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38	1	3,418				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45	2	5,010				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	12	20,299		8	3,416	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	1,296				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	12	23,491		8	4,353	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	12	10,982		7	1,848	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 195,711	$		$ 43,093	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						9,250	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						220,143	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 229,393	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						21,729	1
2	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						14,846	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 36,575	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	LINE OF CREDIT				651,000			33,327	6
7	AI CREDIT CORP			INSURANCE FINANCING							5,032	7
8												8
9	TOTAL Facility Related						$	$ 651,000			$ 38,359	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(31,555)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (31,555)	14
15	TOTALS (line 9+line14)						$	$ 651,000			$ 6,804	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME						$	$			$ (56,283)	1
2	OTHER INTEREST EXPENSE										18,413	2
3	ALLOC. DYNAMIC	X									6,315	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (31,555)	21

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	241,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	246,929	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,929	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	247,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	233	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	253,162	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	346,815	8
	1998	251,196	9
	1999	249,510	10
	2000	236,160	11
	2001	242,302	12

ACCRUAL = 2001 TAX X 1.02
242,302 X 1.02 = 247,000 (ROUNDED)
DYNAMIC ALLOCATION - $4627

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODBRIDGE NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-35-217-015-000	LONG TERM CARE PROPERTY	$ 72,970.08	$ 72,970.08
2.	13-35-217-016-000	LONG TERM CARE PROPERTY	$ 96,361.53	$ 96,361.53
3.	13-35-217-017-000	LONG TERM CARE PROPERTY	$ 72,970.08	$ 72,970.08
4.	10-23-404-059-000	DYNAMIC ALLOCATION	$ 26,130.18	$ 4,299.25
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 268,431.87	$ 246,600.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WOODBRIDGE NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034157

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,560 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	3,000		20	150	150	2,012	9
10	Various			1990	20,717		20	1,036	1,036	13,334	10
11	Various			1991	11,182		20	559	559	6,474	11
12	Various			1992	14,078		20	704	704	7,424	12
13	Various			1993	122,812		20	6,140	6,140	59,405	13
14	Various			1995	20,549		20	1,028	1,028	7,489	14
15	Various			1996	8,331		20	417	417	2,798	15
16	Various			1997	35,913		20	1,795	1,795	10,170	16
17	Various			1998	50,252		20	2,514	2,514	11,596	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		72,986	1,871		2,085	214	19,463	68
69	Financial Statement Depreciation			12,322			(12,322)		69
70	TOTAL (lines 4 thru 69)		$ 359,820	$ 14,193		$ 16,428	$ 2,235	$ 140,165	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 359,820	$ 14,193		$ 16,428	$ 2,235	$ 140,165	1
2	FLOORING	1999	2,599		20	130	130	520	2
3	FIXTURES	1999	1,058		20	53	53	212	3
4	DRAPES/CORNICES	1999	699		20	35	35	140	4
5	CARPETING	1999	440		20	22	22	88	5
6	MICROSCAN UNIT	1999	1,323		20	66	66	264	6
7	BOILER TUBING	1999	2,846		20	142	142	568	7
8	HANDRAILS/GUARDS	1999	570		20	29	29	114	8
9	DOOR SYSTEM	1999	800		20	40	40	153	9
10	DOORS/CLOSETS	1999	1,321		20	66	66	253	10
11	TILES/LIGHTS	1999	1,492		20	75	75	288	11
12	FIRE ALARM SYSTEM	1999	2,440		20	122	122	468	12
13	DOOR MAGNETS	1999	915		20	46	46	173	13
14	DOOR MAGNETS	1999	2,034		20	102	102	383	14
15	DOOR MAGNETS	1999	645		20	32	32	120	15
16	CIRCUITS/OUTLETS	1999	1,350		20	68	68	255	16
17	DOOR/TILING	1999	735		20	37	37	136	17
18	CORNER GUARDS	1999	750		20	38	38	139	18
19	TILING	1999	1,498		20	75	75	269	19
20	INSTALL CERAMIC TILE	1999	720		20	36	36	129	20
21	DOOR/WALL REPAIRS	1999	690		20	35	35	125	21
22	ROOM SIGNS	1999	3,722		20	186	186	744	22
23	SHOWER WALLS	1999	720		20	36	36	123	23
24	WOOD DOORS	1999	350		20	18	18	62	24
25	INSTALL CERAMIC TILE	1999	720		20	36	36	123	25
26	DRYWALL SUPPLIES	1999	142		20	7	7	24	26
27	DRYWALL SUPPLIES	1999	106		20	5	5	17	27
28	DRYWALL SUPPLIES	1999	43		20	2	2	7	28
29	DRYWALL SUPPLIES	1999	731		20	37	37	126	29
30	VCT	1999	1,551		20	78	78	267	30
31	LIGHT FIXTURES	1999	1,696		20	85	85	290	31
32	WALL TILE	1999	773		20	39	39	133	32
33	DOOR RESTRICT DEVICE	1999	5,220		20	261	261	870	33
34	TOTAL (lines 1 thru 33)		$ 400,519	$ 14,193		$ 18,467	$ 4,274	$ 147,748	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 400,519	$ 14,193		$ 18,467	$ 4,274	$ 147,748	1
2	LIGHTING FIXTURE	1999	2,049		20	102	102	323	2
3	CEILING TILES	1999	1,315		20	66	66	209	3
4	TILING	1999	9,796		20	490	490	1,674	4
5	TILING	1999	3,870		20	194	194	663	5
6	SECURITY	1999	2,345		20	117	117	361	6
7	PAINT & DECORATIONS	1999	4,239		20	212	212	654	7
8	WALLPAPER	1999	3,929		20	196	196	588	8
9	CARPETING	2000	7,671		20	384	384	1,152	9
10	CARPETING	2000	2,790		20	140	140	420	10
11	COVE BASE	2000	358		20	18	18	54	11
12	FIXTURES	2000	793		20	40	40	120	12
13	RAILS & COVE BASE	2000	6,000		20	300	300	900	13
14	DUCT DETECTORS	2000	986		20	49	49	143	14
15	FIRE ALARM REPAIRS	2000	1,361		20	68	68	198	15
16	DUCT DETECTORS	2000	489		20	24	24	70	16
17	FIRE ALARM REPAIRS	2000	362		20	18	18	53	17
18	HANDRAILS & BUMPERS	2000	1,670		20	84	84	252	18
19	HANDRAILS & BUMPERS	2000	461		20	23	23	69	19
20	CUBICLE CURTAINS	2000	516		20	26	26	78	20
21	CUBICLE TRACK	2000	125		20	6	6	18	21
22	CUBICLE TRACK	2000	175		20	9	9	27	22
23	REPAIR WALLS	2000	1,611		20	81	81	243	23
24	NEW COIL	2000	1,320		20	66	66	193	24
25	INSTALL COIL	2000	710		20	36	36	105	25
26	ELEVATOR CARPET	2000	1,230		20	62	62	181	26
27	INSTALL TEST HEADER	2000	2,146		20	107	107	303	27
28	CARPET & COVE BASE	2000	2,624		20	131	131	382	28
29	WINDOW TREATMENTS	2000	1,377		20	69	69	201	29
30	VERTICAL BLINDS	2000	543		20	27	27	81	30
31	FIRE ALARM REPAIR	2000	815		20	41	41	106	31
32	INSTALL DYNALOCK	2000	1,453		20	73	73	158	32
33	ELECTRICAL FEED	2000	700		20	35	35	76	33
34	TOTAL (lines 1 thru 33)		$ 466,348	$ 14,193		$ 21,761	$ 7,568	$ 157,803	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 466,348	$ 14,193		$ 21,761	$ 7,568	$ 157,803	1
2	WALLPAPER	2000	1,472		20	74	74	222	2
3	PAINT/BORDERS	2000	2,885		20	144	144	432	3
4	PAINT/WALLPAPER	2000	780		20	39	39	111	4
5	WALLPAPER	2000	483		20	24	24	68	5
6	ARTWORK	2000	1,813		20	91	91	258	6
7	HVAC REPAIR	2000	893		20	45	45	105	7
8	PHONE SYSTEM	2000	10,894		20	545	545	1,226	8
9	WATER COOLER	2001	531		20	27	27	52	9
10	ROOF REPAIR	2001	1,190		20	60	60	110	10
11	WATER PROOFING	2001	750		20	38	38	70	11
12	ELECTRIC IMPROV	2001	1,270		20	64	64	101	12
13	SPLIT HEATING SYSTEM	2001	6,360		20	318	318	504	13
14	FURNACE	2001	32,000		20	1,600	1,600	2,533	14
15	CHILLER REPAIR	2001	1,180		20	59	59	93	15
16	TILE FLOOR	2001	1,300		20	65	65	103	16
17	FIRE ALARM WIRING	2001	775		20	39	39	59	17
18	SIGN	2001	716		20	36	36	54	18
19	AIR COND COILS	2001	2,210		20	111	111	167	19
20	BOILER TUBING	2001	2,851		20	143	143	203	20
21	TUCK POINTING	2001	750		20	38	38	54	21
22	CONCRETE PAVING/STAL	2001	4,754		20	238	238	317	22
23	FIRE ALARM WIRING	2001	775		20	39	39	59	23
24	BOILER TUBING	2001	4,916		20	246	246	267	24
25	ELECTRICAL WORK	2001	605		20	30	30	53	25
26	COMPRESSOR	2002	517		20	34	34	34	26
27	DRAPERY	2002	2,667		20	46	46	46	27
28	WARDROBE ROOM	2002	18,175		20	272	272	272	28
29	COOLER UNIT	2002	900		20	15	15	15	29
30	AIR COIL	2002	2,300		20	34	34	34	30
31	SPRINKLER HEADS	2002	2,455		20	21	21	21	31
32	MOTOR	2002	1,421		20	9	9	9	32
33	WORK STATION	2002	11,900		20	51	51	51	33
34	TOTAL (lines 1 thru 33)		$ 588,836	$ 14,193		$ 26,356	$ 12,163	$ 165,506	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 588,836	$ 14,193		$ 26,356	$ 12,163	$ 165,506	1
2	DUCT DEFLECTORS	2002	5,986		20	64	64	64	2
3	THERAPY ROOM IMPROVEMENT	2002	15,746		20	34	34	34	3
4	TILING/FLOORING	2002	18,311		20	39	39	39	4
5	FAUCETS & SINKS	2002	132		20				5
6	BLINDS	2002	262		20	1	1	1	6
7	FIRE ALARMS	2002	877		20	44	44	44	7
8	AC REPAIRS	2002	550		20	28	28	28	8
9	EYEWASH MACHINE	2002	863		20	43	43		9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 631,563	$ 14,193		$ 26,609	$ 12,416	$ 165,715	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 72,986	$ 1,871	35	$ 2,085	$ 214	$ 19,463	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 72,986	$ 1,871		$ 2,085	$ 214	$ 19,463	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 292,197	$ 26,446	$ 28,123	$ 1,677	10	$ 158,939	71
72	Current Year Purchases	95,458	39,761	7,046	(32,715)	10	6,930	72
73	Fully Depreciated Assets	126,220				10	126,219	73
74								74
75	TOTALS	$ 513,875	$ 66,207	$ 35,169	$ (31,038)		$ 292,088	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	DODGE TRUCK	1993	$ 24,451	$ 1,675	$	$ (1,675)	5	$ 24,451	76
77		ALLOC. DYNAMIC	1900	9,262	2,612	6,426	3,814	5		77
78										78
79										79
80	TOTALS			$ 33,713	$ 4,287	$ 6,426	$ 2,139		$ 24,451	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,179,151	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,687	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,204	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (16,483)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 482,254	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WOODBRIDGE BUILDING, LLC LEASING FROM PALMER BUILDING, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		222		$ 1,092,930			3
4	Additions							4
5								5
6								6
7	TOTAL		222		$ 1,092,930 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 7/1/95
Ending 6/30/15

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 1092930
13.	/2004	$ 1092930
14.	/2005	$ 1092930

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 4,590 Description: $75 - TABLES; $775 OXYGEN CONCENTRATORS; $3740 - COPIER
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	LEXUS RX 300	$ 594.00	$ 7,124	17
18	ALLOC-DYNAMIC			13,536	18
19					19
20					20
21	TOTAL		$ 594.00	$ 20,660	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 77,960	$		$ 77,960	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,166			1,166	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			160,103			160,103	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				97,460		97,460	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						51,332		51,332	13
14	TOTAL			$		$ 239,229	$ 148,792		$ 388,021	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 75,585	$ 75,625	1
2	Cash-Patient Deposits	117,478	117,478	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,179,578	1,179,578	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,049	84,049	6
7	Other Prepaid Expenses	825	825	7
8	Accounts Receivable (owners or related parties)	735,676	745,676	8
9	Other(specify): See Supplemental Schedule	548	548	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,193,739	$ 2,203,779	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	500,383	500,383	15
16	Equipment, at Historical Cost	533,686	533,686	16
17	Accumulated Depreciation (book methods)	(514,479)	(514,479)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,949	7,949	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,949)	(7,949)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	570	713,147	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 520,160	$ 1,232,737	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,713,899	$ 3,436,516	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 458,955	$ 458,955	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	117,478	117,478	28
29	Short-Term Notes Payable	651,000	651,000	29
30	Accrued Salaries Payable	253,542	253,542	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,857	5,857	31
32	Accrued Real Estate Taxes(Sch.IX-B)	247,000	247,000	32
33	Accrued Interest Payable	2,773	2,773	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,435	6,435	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,743,040	$ 1,743,040	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,743,040	$ 1,743,040	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 970,859	$ 1,693,476	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,713,899	$ 3,436,516	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 976,774	1	
2	Restatements (describe):		2	
3	STATE REPLACEMENT TAX RESTATEMENT	(6,274)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 970,500	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	466,559	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(466,200)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 359	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 970,859	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,965,746	1
2	Discounts and Allowances for all Levels	(889,564)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,076,182	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	711,860	6
7	Oxygen	13,731	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 725,591	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	146,695	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,168	19
20	Radiology and X-Ray	2,250	20
21	Other Medical Services	187,582	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 347,695	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	58,908	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 58,908	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	593	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 593	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,208,969	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,247,901	31
32	Health Care	2,705,148	32
33	General Administration	1,792,334	33
	B. Capital Expense		
34	Ownership	1,487,461	34
	C. Ancillary Expense		
35	Special Cost Centers	388,021	35
36	Provider Participation Fee	121,545	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,742,410	40
41	**Income before Income Taxes (line 30 minus line 40)****	466,559	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 466,559	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,853	1,963	$ 67,249	$ 34.26	1
2	Assistant Director of Nursing	1,527	1,679	64,332	38.32	2
3	Registered Nurses	32,063	34,008	805,798	23.69	3
4	Licensed Practical Nurses	16,585	18,091	365,104	20.18	4
5	Nurse Aides & Orderlies	102,329	108,387	934,544	8.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,829	2,022	20,284	10.03	9
10	Activity Assistants	14,353	15,001	98,873	6.59	10
11	Social Service Workers	3,005	3,141	46,030	14.65	11
12	Dietician					12
13	Food Service Supervisor	1,989	2,142	40,522	18.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,010	26,204	198,784	7.59	15
16	Dishwashers					16
17	Maintenance Workers	6,087	6,582	75,349	11.45	17
18	Housekeepers	25,802	27,464	200,259	7.29	18
19	Laundry	13,455	14,340	102,164	7.12	19
20	Administrator	1,957	2,126	100,011	47.04	20
21	Assistant Administrator	1,043	1,043	11,629	11.15	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,773	9,369	109,942	11.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,923	2,123	23,785	11.20	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	258,583	275,685	$ 3,264,659 *	$ 11.84	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	358	$ 7,200	01-03	35
36	Medical Director	72	3,600	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	96	3,072	10-03	38
39	Pharmacist Consultant	169	6,760	10-03	39
40	Physical Therapy Consultant	97	5,335	10a-03	40
41	Occupational Therapy Consultant	91	4,823	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	95	4,859	10a-03	43
44	Activity Consultant	94	4,290	11-03	44
45	Social Service Consultant	66	3,482	12-03	45
46	Other(specify)				46
47	DART CHARTS - NURSE CONS	MONTHLY	38,344	10-03	47
48	UR REVIEW	24	1,200	10-03	48
49	TOTAL (lines 35 - 48)	1,162	$ 82,965		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	502	$ 8,983	10-03	50
51	Licensed Practical Nurses	1,044	18,781	10-03	51
52	Nurse Aides	829	39,589	10-03	52
53	TOTAL (lines 50 - 52)	2,375	$ 67,353		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JAY GONZALEZ	ADMINSTRATOR	0	$ 100,011
IRIS EHRLICHER	ASST. ADMIN.	0	11,629
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 111,640

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - DYNAMIC HEALTHCARE	$ 153,103
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 153,103

C. Professional Services

Vendor/Payee	Type	Amount
DYNAMIC HEALTHCARE CONS	BOOKKEEPING SERVICE	$ 359,800
ECONOCARE, INC.	PURCHASING CONS.	3,996
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	2,230
CHIZEK CONSULTING	OSHA CONSULTING	2,400
SACHNOFF & WEAVER	LEGAL FEES	9,221
HEALTH DATA SYSTEMS	DATA PROCESSING	5,643
FR&R	ACCOUNTING	25,820
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 409,110

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,939
Unemployment Compensation Insurance	35,435
FICA Taxes	244,938
Employee Health Insurance	231,892
Employee Meals	57,707
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	7,500
EMPLOYEE BENEFITS	14,203
TOTAL (agree to Schedule V, line 22, col.8)	$ 689,614

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,591
Health Care Worker Background Check	739
(Indicate # of checks performed 106)	
ADVERTISING AND PROMOTION	32,369
DUES	8,386
LICENSES AND FEES	2,551
ALLOC. DYNAMIC	1,080
Less: Public Relations Expense	( )
Non-allowable advertising	(29,955)
Yellow page advertising	(2,414)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,547

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,250
ALLOC. DYNAMIC	424
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,674

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number WOODBRIDGE NURSING PAVILION # 0034157 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $11705**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,142** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **121,545**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **57,707** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln14**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees